Patient Name: ________________________Primary Physician:______________________
Age: ________Sex: **M F** Referring Physician:________________________________

Patient's Medical History:

• Stroke	Y	N	Date:___________
• Angina/Heart Attack	Y	N	Date:___________
• Congestive Heart Failure	Y	N	
• Pneumonia/ Tuberculosis	Y	N	
• Emphysema/Bronchitis/Asthma	Y	N	
• Kidney Disease/Kidney Failure	Y	N	
• High Blood Pressure	Y	N	
• Diabetes:	Y	N	
Insulin:	Y	N	
• Peptic Ulcer Disease	Y	N	
• Liver Disease	Y	N	
• Thyroid Disease	Y	N	
• Seizures:	Y	N	
Medications for Seizures	Y	N	
• Cancer (Site the location of cancer)	Y	N	Site: _____________

History of:

• Previous blood transfusions	Y	N	
• Bleeding Problem	Y	N	
• Will accept blood transfusions	Y	N	**(If Necessary)**
• Tobacco Use	Y	N	
• Alcohol Use	Y	N	

Previous Operations:

	Type:	Date:	Hospital:
1.	______________________________	________________	___________________
2.	______________________________	________________	___________________
3.	______________________________	________________	___________________
4.	______________________________	________________	___________________
5.	______________________________	________________	___________________

Medications currently used:

____
____

Allergies (If any)	Reactions:
1.________________________________	________________________________
2.________________________________	________________________________
3.________________________________	________________________________

Latex Allergy: Y N
Do you have a living will? Y N
Do you have a healthcare designate? Y N if yes: Name:_______________
Patient Signature: ____Date:_______________

OFFICE USE ONLY:

Information Reviewed By: _________________________________Date:_______________